

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-007496

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS SUB

AMENDED

Registrar's District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

FILED FEB 19 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Lincoln County		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lincoln	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bedford TWP.		c. CITY OR TOWN Troy	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Thalman's Rest Home		d. STREET ADDRESS 450 BUCHANAN	
3. NAME OF DECEASED (Type or print) First Middle Last Letha May Finnerty		4. DATE OF DEATH Month Day Year February 13 1963	
5. SEX Female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-18-1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) Lincoln County Mo.	
13a. FATHER'S NAME Cyrus Taylor		14. NAME OF HUSBAND OR WIFE William B. Finnerty	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) no		17. INFORMANT Elizabeth Finnerty	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Senility		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from 10/5/62 to 2/13/63 and last saw her alive on 2/13/63 Death occurred at 7:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22b. ADDRESS Troy Mo	
22a. SIGNATURE Joseph J. Marsh		22c. DATE SIGNED 2/15/63	
23a. BURIAL, CREATION, REMOVAL (Specify) Burial		23b. DATE 2-17-63	
23c. NAME OF CEMETERY OR CREMATORY Harmony Grove		23d. LOCATION (City, town, or county) Lincoln County Mo.	
24. FUNERAL DIRECTOR Joseph J. Marsh		25. DATE RECD. BY LOCAL REG. 2-15-1963	
		26. REGISTRAR'S SIGNATURE Charlotte Lusk	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

FEB 20 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Gaulnick

Licensed Embalmer No.

4012

P. O. Address

Elsherry, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.